Northwestern Memorial® Hospital

NMH Health History Form
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NMH Preoperative Clinic
233 East Superior Street
Chicago, Illinois 60611
312-926-4343

FOR PHYSICIAN'S OFFICE USE ONLY

Physician ______________________________

Procedure ______________________________

Procedure date ______________________________

FAX this completed form to: **312-926-9081**

Name ______________________________

E-mail address ______________________________

Phone number (Day) ______________________________

Phone number (Evening) ______________________________

Preferred method of contact ______________________________

Primary care physician ______________________________

Physician office location ______________________________

Physician office phone ______________________________

MEDICAL HISTORY: List all past **surgeries** and **hospitalizations**

Reason (type of surgery or illness)	at NMH?	Year

MEDICATIONS: List all of your **medications** here or attach a list (include supplements, vitamins, and over the counter medications)

Name	Dose	# times / day

Date of birth ______________________________

Gender FEMALE MALE

Height ____________ Weight ____________

Occupation ______________________________

Marital status ______________________________

Do you need an interpreter? YES NO

If so, what language? ______________________________

1. Have you ever had a problem with anesthesia?

   YES NO

   If yes, what type of problem?

   ____

   ____

2. Has anyone in your family ever had problems with anesthesia?

   UNSURE YES NO

   If yes, what type of problem?

   ____

   ____

3. Do you have any allergies to medications?

   YES NO

   If yes, what medications and what reactions have you had?

   ____

   ____

   ____

4. Are you allergic to latex or other materials?

   YES NO

   If yes, what material & what reaction did you have?

   ____

   ____

5. Have you ever been treated at Northwestern Memorial Hospital before?

   YES NO

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Name ____

Do you have any of the following problems? In each category, please check ALL that apply.

Category				
Heart/Artery Problems	□ Chest pain or angina □ Heart attack □ Angioplasty or heart stents □ Heart surgery □ Atrial fibrillation □ Heart failure □ Peripheral vascular disease	□ Blockages in your arteries □ Aortic aneurysm □ Heart valve disease (not MVP) □ Defibrillator (AICD) □ Pacemaker		□ High blood pressure □ NONE
Lung Problems	□ Emphysema □ COPD □ Recent pneumonia (last 3 months)	□ Use of Oxygen at home □ Recent TB (tuberculosis) □ Pulmonary hypertension □ Cold or flu in last week		□ Asthma □ NONE
Sleep Problems	□ Loud snoring □ Stop breathing during sleep or have sleep apnea □ CPAP			□ Daytime drowsiness □ NONE
Liver or Stomach Problems	□ Active Crohn's or Ulcerative Colitis □ Recent stomach ulcer	□ Hepatitis □ Cirrhosis □ Liver transplant		□ Reflux or GERD □ Hiatal hernia □ NONE
Urine or Kidney Problems	□ Impaired kidney function □ Dialysis □ Kidney transplant			□ Bladder infection or UTI □ NONE
Gland Problems	□ Diabetes □ Take prednisone or other steroids	□ Adrenal problems □ Pituitary problems		□ Thyroid problems □ NONE
Brain, Spinal Cord, Nervous System Disease	□ Stroke or TIA □ MS (Multiple Sclerosis) □ Parkinson's □ Brain aneurysm or AVM	□ Brain tumor □ Spinal cord injury □ Myasthenia Gravis □ Muscular Dystrophy		□ Seizure Disorder □ Cerebral Palsy □ NONE
Skin Problems	□ Active Shingles □ New rash or open wound			□ Eczema □ NONE
Bleeding or Clotting Disorder	□ Hemophilia □ Bleeding disorder □ Bleed or bruise easily	□ Sickle Cell Disease □ Blood clots □ Anemia □ Use blood thinner medications		□ Family history of bleeding disorder □ NONE
Other Issues	□ Active Leukemia or lymphoma □ Multiple Myeloma □ Chemotherapy in last 6 weeks	□ Amyloidosis □ HIV		□ Mood or psychiatric disorders □ NONE

Question			
Are you a Jehovah's Witness?	YES		NO
Are you currently pregnant?	YES		NO
Have you had unplanned weight loss of more than 20 pounds in the last 6 months?	YES		NO
Have you smoked for more than 25 years (now or ever)?	YES		NO
Do you drink more than 2 alcoholic drinks per day or 14 drinks per week?	YES		NO
Have you used recreational drugs other than marijuana in the last 3 months? If so, what kind? ____ Do you have other significant medical problems? If so, what are they? ____	YES		NO